

DOC. NO.  
26-06-00-99/08/20OFFICE OF  
VITAL  
STATISTICSCERTIFICATE OF DEATH  
State of Delaware (107)

LOCAL REG NO.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATE FILE NUMBER

## DECEDENT

TO FUNERAL DIRECTOR: After certificate has been signed by attending physician and completely filled in by funeral director, remove carbons, file parts 1 and 2 with Registrar within 72 hrs. after death and then use Burial-Traavel Permit for disposition of body.

## PARENTS

## INFORMANT

## DISPOSITION

## PRONOUNCING OFFICIAL

ITEMS 27-29 MUST BE COMPLETED BY PHYSICIAN OR NURSE WHO PRONOUNCES DEATH

SEE DEFINITION ON OTHER SIDE

## CERTIFIER

TO HOSPITAL OR PHYSICIAN — DELAWARE LAW  
REQUIRES THAT THE DEATH CERTIFICATE BE  
EXECUTED WITHIN 72 HOURS AFTER DEATH

1. DECEDENT'S NAME (FIRST, MIDDLE, LAST) <b>Marissa R Fishman</b>		2. SEX <b>F</b>	3. DATE OF DEATH (MO., DAY, YR.) <b>8/30/02</b>
4. SOCIAL SECURITY NO.	5A. AGE (YRS) <b>20</b>	5B. UNDER 1 YEAR MONTHS <b>20</b>	5C. UNDER 1 DAY HOURS <b>20</b>
6. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO	8. ANATOMICAL GIFT <input type="checkbox"/> CONSENT GRANTED <input type="checkbox"/> NOT GRANTED	10A. PLACE OF DEATH (CHECK ONLY ONE, SEE INSTRUCTIONS ON OTHER SIDE) <input checked="" type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> ODA <input type="checkbox"/> OTHER NURSING HOME <input type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (SPECIFY)	
10B. FACILITY NAME (IF NOT INSTITUTION GIVE STREET AND NUMBER) <b>A. I. Dupont Hospital for Children</b>		10C. CITY, TOWN OR LOCATION OF DEATH <b>Wilmington</b>	
11. MARITAL STATUS — MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPEC.)		12. SURVIVING SPOUSE (IF WIFE GIVE MAIDEN NAME)	
13A. DECEDENT'S USUAL OCCUPATION (KIND OF WORK DURING MOST OF WORKING LIFE, DO NOT USE RETIRED)		13B. KIND OF BUSINESS/INDUSTRY	
14A. RESIDENCE — STATE <b>Pennsylvania</b>	14B. COUNTY <b>Chadds Ford</b>	14C. CITY, TOWN OR LOCATION <b>110 Kelly Drive</b>	
14D. INSIDE CITY LIMITS? (YES OR NO)	14E. ZIP CODE <b>(Specify)</b>	15. RACE — AMERICAN INDIAN, BLACK, WHITE, ETC. (SPECIFY) <b>White</b>	
16. FATHER'S NAME (FIRST, MIDDLE, LAST)		17. MOTHER'S NAME (FIRST, MIDDLE, MAIDEN SURNAME)	
20A. INFORMANT'S NAME (TYPE/PRINT)		20B. MAILING ADDRESS (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE, ZIP CODE)	
21A. METHOD OF DISPOSITION <input type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL FROM STATE <input type="checkbox"/> DONATION <input type="checkbox"/> OTHER (SPECIFY)		21B. PLACE OF DISPOSITION (NAME OF CEMETERY, CREMATORY, OR OTHER PLACE)	
21C. LOCATION (CITY, TOWN, STATE)		22A. SIGNATURE OF FUNERAL DIRECTOR <b>Schoenberg</b>	
24. REGISTRAR'S SIGNATURE		26. DATE FILED (MO., DAY, YR.)	
27. TIME OF DEATH <b>7:03</b> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		28. DATE PRONOUNCED DEAD (MO., DAY, YR.) <b>08-30-02</b>	
29. WAS CASE REFERRED TO MEDICAL EXAMINER? (YES OR NO) <b>YES</b>		30A. CERTIFIER (CHECK ONLY ONE) <input type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 26) <input checked="" type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying the cause of death) <input checked="" type="checkbox"/> MEDICAL EXAMINER (On the basis of examination done by myself, delay and place, and due to the cause(s) and manner as stated.)	
30B. SIGNATURE (PRINT NAME AND TITLE OF CERTIFIER) <b>GLENN STRYJEWSKI, M.D. A.I. Dupont Hospital</b>		30C. LICENSE NUMBER <b>MD</b>	
30D. DATE SIGNED (MO., DAY, YR.) <b>8/30/02</b>		31. DATE OF INJURY <b>8/30/02</b>	
32. MANNER OF DEATH <input type="checkbox"/> NATURAL <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> UNDETERMINED		33. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. (SPECIFY)) <b>Child fell into Pool</b>	
34. TIME OF INJURY <b>7:00</b> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		35. LOCATION (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE) <b>3220 Coachman Rd., Surrey Park, Wilmington, DE</b>	
40. PART I DO NOT ENTER THE MODE OF DYING SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE PER EACH LINE.			
IMMEDIATE CAUSE (FATAL DISEASE, INJURY OR CONDITION THAT IN YOUR OPINION CAUSED THE DEATH) <b>Drowning</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (DISEASE OR INJURY WHICH INITIATED EVENTS RESULTING IN DEATH) LAST.			
PART II OTHER SIGNIFICANT CONDITIONS— CONTRIBUTING TO CAUSE OF DEATH			

REV. 9/99

(1) ORIGINAL COPY—STATE

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